HIP Preliminary Study
April 15, 2008
Draft v4.1

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Issue	Question	Proposed Assumptions for BASE CASE (2010, based on HB 2537)	Proposed Assumptions for PRELIMINARY EXPANDED PARTNERSHIP (2010)
Basic operating principle for HIP	▪ Market organizer?	▪ HIP remains a market organizer.	▪ Same as base case.
Target population	▪ Whom does the HIP aim to serve, and why? ▪ All small employers? ▪ Some small employers, e.g., those with many low-wage employees? ▪ To increase offer rates of employers? Increase take-up rates of employees? ▪ To stem deterioration in current offer & take-up? Reach non-offering employers?	▪ Employers with 2-50 employees that do not currently offer health insurance and at least 50% of employees are low-wage workers, where low-wage is defined at an amount consistent with 200% FPL for single employee **(2537).** ▪ HIP directed to make every effort to coordinate coverage of dependent children with Medicaid/SCHIP, consistent with the Dept of Social and Health Services employer-sponsored insurance program **(2537).** ~~▪ All small employers.~~ ~~▪ Low-income small-group workers (and former employees) offered limited subsidies, calibrated to income.~~ ▪ Workers and dependents covered in large groups continue to be ineligible. ▪ No coordination with Basic Health (BH). ▪ Continued, no waiting period for employer eligibility.	▪ All small employers and individuals. **(Based upon Board's decision in Nov 2007 on scope of studies –combined market for all populations covered in expanded HIP).** [The Preliminary Report needs to study the results of incorporating the individual and small group markets into HIP. Since the design of the study needs to include the entire small group market, participation of small employers cannot be limited to just those that do not currently offer health insurance and employ at least 50% low-wage workers.] ▪ Otherwise, same as base case. [Further exploration by HCA is needed on how HIP and Medicaid/SCHIP can coordinate coverage of dependent children consistent with the Dept of Social and Health Service's employer-sponsored insurance program. Mathematica will then need to design a way to estimate the impact upon HIP coverage and expenditures of this coordinated coverage.]

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Eligibility	**Participation** ▪ Who is eligible to participate in terms of joining and staying?	~~▪ All small employers and active employees eligible for group coverage.~~ ▪ COBRA enrollees **(2537).** ▪ Continued, retirees under age 65 cannot participate. ▪ Employers with 2-50 employees that do not currently offer health insurance and at least 50% of employees are low-wage workers, where low-wage is defined at an amount consistent with 200% FPL for single employee **(2537).**	o All small employers and active employees eligible for group coverage. o Individuals accepted for coverage (no guaranteed issue). o Former employees; do not necessarily have to be COBRA enrollees **(2537).** o Continued, retirees under age 65 cannot participate.
	Subsidy ▪ Who is eligible for subsidy? *(this question added to matrix after 3.6.08 Board meeting because of revision in 2537 regarding not currently offering and at least 50% low-wage workers).*	▪ All low-income (family income does not exceed 200% of poverty level) individuals in small group plans are eligible for premium subsidy.	o All low-income individuals enrolled in individual (non-group) and small group plans are eligible for premium subsidy **(recommendation).** o WSHIP and its subsidy schedule will not change. This decision retains the scope of the Preliminary Study described in law **(recommendation).**

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Product designation	~~Will more than four plan designs be offered?~~ ▪ How will the designated plans differ? ▪ How will the most comprehensive plan compare to BH, in anticipation of ultimately offering BH (per the final study) in the HIP? ▪ Are all HIP plans eligible for subsidy, or only some?	▪ Up to 5 health benefit plan designs chosen by the Board, with multiple deductible and point-of-service cost-sharing options **(2537).** ▪ One health benefit plan shall be a high deductible health plan accompanied by a health savings account **(2537).** ▪ Health benefit plans shall range from catastrophic to comprehensive *(current law but added to matrix after 3.6.08 Board meeting).* ~~Four product designs offered, including one catastrophic (HSA-qualified) plan.~~ ~~All products in HIP are aligned with (actuarially equivalent to) one of the 4 plan designs.~~ ▪ All plans offered through HIP are eligible for subsidy **(assumption).** ▪ The model will not track plan choice at the carrier level. Therefore, the model will not consider the number of carriers in the HIP. [A time/resource constraint.]	~~Same as base case.~~ ▪ Up to 5 health benefit plan designs chosen by the Board, with multiple deductible and point-of-service cost-sharing options **(2537) (recommendation).** ▪ One health benefit plan shall be a high deductible health plan accompanied by a health savings account **(2537).** ▪ To model employee choice of plan, all products in HIP aligned in (actuarially equivalent) plan design "tiers." **(recommendation).** ▪ All plans offered through HIP are eligible for subsidy **(recommendation).** [Some current market products might not be admitted, or they would be modified for the purpose of HIP offer/subsidy. If not admitted, they would be closed.] **Mathematica needs additional information on products available to small employers so it can design how to model available plan choices.**

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Product choice	▪ Who chooses – employer, employee, or both? ▪ All products or a subset of products?	▪ Employee plan choice can be limited in start-up phase **(2537).** ▪ Employers will choose the health plan for the group for the initial implementation on Jan 1, 2009 **(2537)**	▪ Employer chooses to enroll in HIP ▪ All plans are available to employees and individuals. ▪ Unrestricted employee and individual choice among plan types.
Rating	▪ How are small-group rates calculated? ▪ How will small-group rules change in the expanded partnership? ▪ How does the HIP implement subsidies?	▪ Current small group rules: rating by age (3.75:1), location, and family type. ▪ HIP will transmit rates (per product) to employers, and also employee contribution amounts **(assumption).** ▪ HIP will not constrain rating of association plans.	▪ One rating approach for entire HIP—no difference between small group participants and individual participants. **(Based upon Board's decision in Nov 2007 on scope of studies – one market for all populations covered in expanded HIP).** ▪ Otherwise, same as base case.

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Non-medical (administrative) costs	▪ Current medical loss ratio standard for individuals? For small groups? ▪ Will state funds cover the TPA cost?	▪ No small group standard, same as current law. ▪ Rates for individual plans are based upon a minimum medical loss ratio standard of 72% for individual plans. As of July 1, 2008, the medical loss ratio that determines whether a remittance is paid to the high risk pool will range from 74—77% and depend on the actual percentage of applicants a carrier declines for coverage in the individual market **(recommendation).** ▪ HIP surcharge estimate assumed to be $25 pmpm (2008). State funds will cover this cost for the first 5 years **(assumption).** ▪ Carrier administrative costs for every HIP product will be estimated as the average rate calculated across all small group carriers in WA in the past 5 years.	▪ Rates for individual plans are based upon a minimum medical loss ratio standard of 72% for individual plans. As of July 1, 2008, the medical loss ratio that determines whether a remittance is paid to the high risk pool will range from 74—77% and depend on the actual percentage of applicants a carrier declines for coverage in the individual market **(recommendation).** ▪ Carrier administrative costs for individual and small group products will be estimated as the average medical loss ratio calculated across all small group and nongroup carriers in WA in the past 5 years **(assumption).**
Employee participation requirement	▪ Same or different than in current small group market? If different, how?	▪ 75 percent of eligible employees must participate, as in current small group market. **(Reflects Board decision in Feb 2008).**	▪ For small groups, same as base case.
Employer minimum contribution to premium	▪ Where to set? Flat amount or percentage? How important an issue is this for achieving high employee participation?	▪ Retain percentage established by the HIP board, which will be lower than current market. (Current standard is 75 percent for single; 50 percent for family.) **(Board decision in March 2008: 40% for employee only.)**	▪ Same as base case **(assumption). [Note that the 40% minimum contribution becomes the industry standard for small group plans under an expanded HIP.]**

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Section 125	▪ How will the HIP assist small employers in setting up Sec. 125 plans, per statutory requirement? ▪ Will this assistance be available to small employers that do not offer HIP coverage, to help workers pay individual premiums pretax?	▪ Administrative cost of establishing Sec. 125 for each employer assumed to be minimal and funded separately **(assumption).**	▪ Same as base case. ▪ All employers will offer a Section 125 plan to support individual purchase of coverage through HIP. **(recommendation).**
Benchmark for subsidies	▪ Which level of product should be the benchmark – Catastrophic? Medium? Comprehensive?	▪ Adopt Board's decision. ~~High-medium plan will be used as benchmark~~	▪ Same as base case **(recommendation).**
Subsidies – scale and sustainability	▪ Will subsidies be predictable, sustainable, and meaningful? ▪ How will they relate to family income?	▪ Limited premium subsidies calibrated to income based on 2008 BH standard **(recommendation, to be used until premium subsidy schedule developed by the HCA.)**	▪ Low-income persons receive premium assistance (premium subsidy scale developed by the HCA) whether they apply as an individual or through a small group. In small groups, the premium subsidy will apply only to enrolled low-income workers and dependents **(assumption).** ▪ WSHIP subsidy schedule will not change in the Preliminary Study **(recommendation).**

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Adverse selection	▪ Will HIP risk adjust?	▪ If risk adjustment needed, the model will assume that it is implemented successfully **(assumption based upon time/resources constraint: modeling will not be performed at the carrier level).** ▪ WSHIP continues to apply to individual plans (outside of the HIP).	▪ WSHIP continues to apply to individuals purchasing plans through HIP (no guaranteed issue of individual coverage) **(assumption).** ▪ Otherwise, same as base case.
Market alternatives	▪ Are there small group and/or individual markets running in parallel with HIP? ▪ How do AHPs interact when HIP is available in the small group market?	▪ HIP is available within the small group market. HIP and non-HIP enrollees pooled for rating purposes. ▪ AHPs: - Employers choose between the small group and AHP markets based on employer cost and employee participation. - Full mobility among small group, HIP within small group, and AHP coverage. ▪ Voluntary coverage.	▪ No competing small group or individual markets ▪ State programs (BH, Medicaid, SCHIP) continue to be an option for low-income individuals. ▪ AHPs: same as base case. ▪ Voluntary coverage, but Mathematica has offered to also model individual mandate in the preliminary study; individual mandate must be modeled in final study.